

Telecommunications Equipment Purchase Program (TEPP)

“Meeting Needs for Specialized Telephone Equipment”

APPLICATION FOR VOUCHER

Please print your responses. You may direct any questions about the application or the Telecommunications Equipment Purchase Program (TEPP) by calling: (608) 274-4448 TTY, (608) 274-1980 Voice, or email TEPP@williamsyoung.com.

Mail the application to: **USF Fund Administrator, c/o Williams Young, LLC, P.O. Box 8700, Madison, WI 53708-8700 or**

Fax the application to: **USF Fund Administrator, (608) 274-8085**

PERSONAL INFORMATION		DISABILITY (CHECK ONE):	
Applicant's Name (Last, First, Middle) (Maiden, if applicable)		<input type="checkbox"/> Hard of Hearing (Voucher Maximum \$200 and no co-payment required)	
Applicant's Postal Address		<input type="checkbox"/> Deaf/Severely Hard of Hearing (Voucher Maximum \$800)	
City	State	ZIP Code	<input type="checkbox"/> Speech Impaired (Voucher Maximum \$1,600)
Telephone Number: ()		<input type="checkbox"/> TTY <input type="checkbox"/> Voice	<input type="checkbox"/> Mobility Impaired or Motion Impaired (Voucher Maximum \$1,600)
Email Address:		<input type="checkbox"/> Deaf-Low Vision (Voucher Maximum \$2,500)	
Social Security Number:		Date of Birth:	<input type="checkbox"/> Deaf-Blind (Voucher Maximum \$7,200)
HOUSEHOLD INFORMATION		Have you received assistance from the following:	
Number of people in your household: _____		TEPP	TAP
*Annual household income according to most recent tax return filed: \$ _____		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
*(include income of spouse or parent/guardian, if applicable)		When: _____	When: _____
There is no income limit for TEPP assistance. Income information will be used to determine if you may be eligible for the Department of Health and Family Services/TAP (Telecommunications Assistance Program) assistance which can pay the \$100 co-payment for equipment purchases.		<input type="checkbox"/> No	<input type="checkbox"/> No

I certify that I have a disability in the category checked above that limits or curtails my access to or use of telecommunications services. Equipment to be purchased with this voucher is necessary for me to effectively access telecommunications services.

I understand that any deliberate fraud or misuse of this program will result in legal action taken by the State of Wisconsin. I also understand that I need to make a \$100 co-payment at the time the equipment is purchased unless I qualify as a TAP applicant or in the Hard of Hearing Category.

THESE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Applicant or Guardian Signature _____

Date _____

The information requested on this form is authorized for collection to administer the Universal Service Fund pursuant to s. 196.218, Stats., and PSC 160.71, Wis. Adm. Code. The information collected is used to determine eligibility for the Universal Service Fund programs of the Public Service Commission of Wisconsin. Completion of this form is voluntary; however, failure to furnish the requested information may result in denial of eligibility for support under these programs. Personally identifiable information collected on this form is not likely to be used for purposes unrelated to the Universal Service Fund programs.

Applicants are processed in the order they are received. Vouchers will be issued on a first come, first served basis in compliance with rules governing the Universal Service Fund. Specific limitations will apply as identified in PSC §160.07 and 160.071, relating to funding, definition of disability and voucher amount. If the applicant receives a voucher, he/she is responsible for the first \$100 of the equipment purchased, unless he/she is qualified as a TAP recipient or in the Hard of Hearing Category, and any additional amount exceeding the maximum value of the voucher plus the co-payment.

THIS SECTION FOR OFFICE USE ONLY

TEPP	Date received: _____	TAP
<input type="checkbox"/> Eligible		<input type="checkbox"/> Eligible
<input type="checkbox"/> Ineligible: Reason: _____		<input type="checkbox"/> Ineligible: Reason: _____
USF Administer and date: _____		